

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
FACILITY-BASED REHABILITATION SUPPORT
PROGRESS SUMMARY NOTE**

Please Type or Print

Consumer's Name: _____

Month/year: _____

Objective: _____

☐ Accomplished

☐ Making Progress

☐ No Progress

Objective: _____

☐ Accomplished

☐ Making Progress

☐ No Progress

Objective: _____

☐ Accomplished

☐ Making Progress

☐ No Progress

Objective: _____

☐ Accomplished

☐ Making Progress

☐ No Progress

• Activities: ☐ Continue Plan w/o Revision ☐ Revise Plan ☐ Referral

• Health Status ☐ Optimal / Satisfactory ☐ Fair / Poor

• Status of Community Living Skills ☐ Optimal / Satisfactory ☐ Fair / Poor

Comments: _____

Lead Clinical Staff (or designee) _____

Date _____